BlueJourney HMO

SUMMARY OF BENEFITS

BlueJourney Premier, BlueJourney Value, and BlueJourney Essential

Capital BLUE

H3962_18_HMOSB Accepted

Summary of Benefits
January 1, 2018 — December 31, 2018

Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **BlueJourney - Premier, Value, and Essential (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueJourney - Premier, Value, and Essential (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **BlueJourney - Premier, Value, and Essential (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-800-779-6962 (TTY 711).

Things to Know About BlueJourney - Premier, Value, and Essential (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

BlueJourney - Premier, Value, and Essential (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-779-6962 (TTY 711).
- If you are not a member of this plan, call toll-free 1-800-990-4201 (TTY 711).
- Our website: CapitalBlueMedicare.com

Who can join?

To join **BlueJourney - Premier, Value, and Essential (HMO),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Pennsylvania: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Which doctors, hospitals, and pharmacies can I use?

BlueJourney - Premier, Value, and Essential (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. If you don't use providers in our network, your services will not be covered and you will pay more.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (CapitalBlueMedicare.com). Or, call us and we will send you a copy of the provider and pharmacy directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more.*

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, CapitalBlueMedicare.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
Note: • Services with a 1 may require prior authorization. • **Referrals no longer required.**			
Monthly Plan Premium	You pay $148.00 per month. In addition, you must keep paying your Medicare Part **B** premium.	You pay $48.00 per month. In addition, you must keep paying your Medicare Part **B** premium.	You pay $0 per month. In addition, you must continue to pay your Medicare Part **B** premium.
Deductible	You pay $0; deductible does not apply	You pay $0; deductible does not apply	You pay $0; deductible does not apply
Maximum Out-of-Pocket Responsibility (MOOP)	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. **Your yearly limit(s) in this plan:** *$3,400 for services you receive from in-network providers.* If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part **D** prescription drugs. (excludes OTC drugs)	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. **Your yearly limit(s) in this plan:** *$3,400 for services you receive from in-network providers.* If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part **D** prescription drugs. (excludes OTC drugs)	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. **Your yearly limit(s) in this plan:** *$6,700 for services you receive from in-network providers.* If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part **D** prescription drugs. (excludes OTC drugs)

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Covered Medical and Hospital Benefits			
Inpatient Hospital Coverage[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: • $65 copay per day for days 1 through 5 • $0 copay per day for days 6 and beyond A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: • $100 copay per day for days 1 through 5 • $0 copay per day for days 6 and beyond A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: • $150 copay per day for days 1 through 8 • $0 copay per day for days 6 and beyond A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.
Inpatient Mental Health Care[1]	**Inpatient Mental Health Care** For inpatient mental health care, see the "Mental Health Care" section of this booklet.	**Inpatient Mental Health Care** For inpatient mental health care, see the "Mental Health Care" section of this booklet.	**Inpatient Mental Health Care** For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Outpatient Hospital Coverage (Surgery) [1]	**Ambulatory surgical center:** You pay a $100 copay **Outpatient hospital:** You pay a $200 copay Outpatient surgery copay applies to each visit.	**Ambulatory surgical center:** You pay a $200 copay **Outpatient hospital:** You pay a $300 copay Outpatient surgery copay applies to each visit.	**Ambulatory surgical center:** You pay a $225 copay **Outpatient hospital:** You pay a $325 copay Outpatient surgery copay applies to each visit.

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Doctor Visits (Primary Care Providers and Specialists)	**Primary care physician visit:** You pay a $10 copay **Specialist visit:** You pay a $20 copay	**Primary care physician visit:** You pay a $10 copay **Specialist visit:** You pay a $25 copay	**Primary care physician visit:** You pay $5 copay **Specialist visit:** You pay $30 copay
Preventive Care	You pay a $0 copay Our Plan covers many preventative services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling	You pay a $0 copay Our Plan covers many preventative services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling	You pay a $0 copay Our Plan covers many preventative services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Preventive Care continued	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventative visit (one-time)Yearly "Wellness" visit Any additional preventative services approved by Medicare during the contract year will be covered.	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventative visit (one-time)Yearly "Wellness" visit Any additional preventative services approved by Medicare during the contract year will be covered.	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventative visit (one-time)Yearly "Wellness" visit Any additional preventative services approved by Medicare during the contract year will be covered.
Emergency Coverage **Worldwide Emergency Coverage** **Worldwide Maximum Annual Plan Benefit**	You pay a $100 copay per visit (within the U.S.) You pay a $100 copay per visit (Worldwide – outside U.S.) $1,000,000 maximum annual benefit – Combined for Emergency and Urgent Care Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	You pay a $100 copay per visit (within the U.S.) You pay a $100 copay per visit (Worldwide – outside U.S.) $1,000,000 maximum annual benefit – Combined for Emergency and Urgent Care Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	You pay a $80 copay per visit (within the U.S.) You pay a $80 copay per visit (Worldwide – outside U.S.) $1,000,000 maximum annual benefit – Combined for Emergency and Urgent Care Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Urgently Needed Services **Worldwide Urgently Needed Services**	You pay a $30 copay per visit (within the U.S.) You pay a $30 copay per visit (Worldwide – outside the U.S.)	You pay a $35 copay per visit (within the U.S.) You pay a $35 copay per visit (Worldwide – outside the U.S.)	You pay a $40 copay per visit (within the U.S.) You pay a $40 copay per visit (Worldwide – outside the U.S.)
Diagnostic Services/Labs / Imaging – Outpatient (costs for these services may vary based on place of service) [1]	**Diagnostic radiology services** (such as MR1s, CT scans): • $75 copay per service **Diagnostic tests and procedures:** • $5 copay per service **Lab services:** • $15 copay for lab services. **Outpatient X-rays:** • $25 copay per service **Therapeutic radiology services (such as radiation treatment for cancer):** • 20% coinsurance	**Diagnostic radiology services** (such as MR1s, CT scans): • $100 copay per service **Diagnostic tests and procedures:** • $10 copay per service **Lab services:** • $15 copay for lab services. **Outpatient X-rays:** • $25 copay per service **Therapeutic radiology services (such as radiation treatment for cancer):** • 20% coinsurance	**Diagnostic radiology services** (such as MRIs, CT scans): • $250 copay per service **Diagnostic tests and procedures:** • $15 copay per service **Lab services:** • $15 copay for lab services. **Outpatient X-rays:** • $50 copay per service **Therapeutic radiology services (such as radiation treatment for cancer):** • 20% coinsurance
Hearing Services	**Exam to diagnose and treat hearing and balance issues:** • $20 copay **Routine hearing exam:** (Limit 1 Routing Hearing Exam Visit per year): • $0 copay	**Exam to diagnose and treat hearing and balance issues:** • $25 copay **Routine hearing exam:** (Limit 1 Routing Hearing Exam Visit per year): • $0 copay	**Exam to diagnose and treat hearing and balance issues:** • $30 copay **Routine hearing exam:** (Limit 1 Routing Hearing Exam Visit per year): • $0 copay

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Hearing Services continued	**Hearing aid fitting/evaluation:** (One fitting/evaluation for Hearing Aid every three years): • $0 copay **Hearing aid:** Our plan pays up to $800 every three years for hearing aids.	**Hearing aid fitting/evaluation:** (One fitting/evaluation for Hearing Aid every three years): • $0 copay **Hearing aid:** Our plan pays up to $800 every three years for hearing aids.	**Hearing aid fitting/evaluation:** (One fitting/evaluation for Hearing Aid every three years): • $0 copay **Hearing aid:** Our plan pays up to $800 every three years for hearing aids.
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $20 copay Medicare-covered dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. **Routine dental services:** $10 copay for one routine dental visit per calendar year includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $25 copay Medicare-covered dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. **Routine dental services:** $10 copay for one routine dental visit per calendar year includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $30 copay Medicare-covered dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. **Routine dental services:** $10 copay for one routine dental visit per calendar year includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded.

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Dental Services[1] continued	**In-Network** 50% Coinsurance applied to plan allowed amounts for the following services: • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics $1,500 maximum plan allowance per calendar year, applies to both in-network and out-of-network services. **Prior authorization required for Medicare-covered dental services.** **Pre-Treatment Estimates are recommended before service is performed.**	**In-Network** 50% Coinsurance applied to plan allowed amounts for the following services: • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics $1,500 maximum plan allowance per calendar year, applies to both in-network and out-of-network services. **Prior authorization required for Medicare-covered dental services.** **Pre-Treatment Estimates are recommended before service is performed.**	**In-Network** 50% Coinsurance applied to plan allowed amounts for the following services: • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics $1,500 maximum plan allowance per calendar year, applies to both in-network and out-of-network services. **Prior authorization required for Medicare-covered dental services.** **Pre-Treatment Estimates are recommended before service is performed.**
Vision Services[1]	**Exam to diagnose and treat diseases and conditions of the eye:** • $20 copay per visit **Annual glaucoma screening for those at risk:** • $0 copay per visit	**Exam to diagnose and treat diseases and conditions of the eye:** • $25 copay per visit **Annual glaucoma screening for those at risk:** • $0 copay per visit	**Exam to diagnose and treat diseases and conditions of the eye:** • $30 copay per visit **Annual glaucoma screening for those at risk:** • $0 copay per visit

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Vision Services[1] continued	**Routine eye exam (One every year)** • $20 copay **Eyeglasses or contact lenses after cataract surgery:** • $0 copay **Eyeglass Frames:** One eyeglass frame every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied. **Standard Eyeglass Lenses:** One pair every 2 calendar years. Plan pays 100% **Elective Contact Lenses:** One order as prescribed every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied.	**Routine eye exam (One every year)** • $20 copay **Eyeglasses or contact lenses after cataract surgery:** • $0 copay **Eyeglass Frames:** One eyeglass frame every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied. **Standard Eyeglass Lenses:** One pair every 2 calendar years. Plan pays 100% **Elective Contact Lenses:** One order as prescribed every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied.	**Routine eye exam (One every year)** • $20 copay **Eyeglasses or contact lenses after cataract surgery:** • $0 copay **Eyeglass Frames:** One eyeglass frame every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied. **Standard Eyeglass Lenses:** One pair every 2 calendar years. Plan pays 100% **Elective Contact Lenses:** One order as prescribed every 2 calendar years. Members pay the balance of charges after a $40 allowance is applied.
Mental Health Services[1]	**Inpatient visit:** • You pay: $65 copay per day for days 1 through 5 • $0 copay per day for days 6 through 90 Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit:** • You pay: $100 copay per day for days 1 through 5 • $0 copay per day for days 6 through 90 Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit:** • You pay: $150 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Mental Health Services[1] continued	The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.	The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.	The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.
Outpatient Mental Health services[1]	**Outpatient group therapy visit:** • $25 copay **Outpatient individual therapy visit:** • $25 copay	**Outpatient group therapy visit:** • $30 copay **Outpatient individual therapy visit:** • $30 copay	**Outpatient group therapy visit:** • $35 copay **Outpatient individual therapy visit:** • $35 copay
Outpatient Substance Abuse[1]	**Group therapy visit:** • $25 copay **Individual therapy visit:** • $25 copay	**Group therapy visit:** • $30 copay **Individual therapy visit:** • $30 copay	**Group therapy visit:** • $35 copay **Individual therapy visit:** • $35 copay

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Skilled Nursing Facility (SNF) 1	**Our plan covers up to 100 days in a SNF.** You pay: • $0 copay per day for days 1 through 5 • $20 copay per day for days 6 through 20 • $160 copay per day for days 21 through 100 A benefit period begins the day you go into a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.	**Our plan covers up to 100 days in a SNF.** You pay: • $0 copay per day for days 1 through 5 • $20 copay per day for days 6 through 20 • $167 copay per day for days 21 through 100 A benefit period begins the day you go into a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. .	**Our plan covers up to 100 days in a SNF.** You pay: • $0 copay per day for days 1 through 5 • $0 copay per day for days 6 through 20 • $167 copay per day for days 21 through 100 A benefit period begins the day you go into a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.
Outpatient Rehabilitation[1]	**Cardiac (heart) Rehabilitation services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • $20 copay **Intensive Cardiac (heart) Rehabilitation** services sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks: • $20 copay	**Cardiac (heart) Rehabilitation services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • $25 copay **Intensive Cardiac (heart) Rehabilitation** services sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks: • $25 copay	**Cardiac (heart) Rehabilitation services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • $30 copay **Intensive Cardiac (heart) Rehabilitation** services sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks: • $30 copay

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Outpatient Rehabilitation[1] Continued	**Pulmonary Rehabilitation services:** • $20 copay **Occupational therapy visit:** • $20 copay **Physical therapy and speech and language therapy visit:** • $20 copay	**Pulmonary rehabilitation services:** • $25 copay **Occupational therapy visit:** • $25 copay **Physical therapy and speech and language therapy visit:** • $25 copay	**Pulmonary rehabilitation services:** • $30 copay **Occupational therapy visit:** • $30 copay **Physical therapy and speech and language therapy visit:** • $30 copay
Ambulance[1]	You pay a $100 copay per trip Prior authorization required for non-emergency services.	You pay a $150 copay Prior authorization required for non-emergency services.	You pay a $200 copay Prior authorization required for non-emergency services.
Transportation	**Not** covered	**Not** covered	**Not** covered
Medicare Part B Drugs (e.g. chemotherapy drugs)[1]	**For Part B drugs, such as Chemotherapy drugs:** You pay a 20% coinsurance **Other Part B drugs:** You pay a 20% coinsurance	**For Part B drugs, such as Chemotherapy drugs:** You pay a 20% coinsurance **Other Part B drugs:** You pay a 20% coinsurance	**For Part B drugs, such as Chemotherapy drugs:** You pay a 20% coinsurance **Other Part B drugs:** You pay a 20% coinsurance
Foot Care (podiatry services) [1]	**Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:**	**Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:**	**Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:**

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Foot Care (podiatry services) [1] continued	$10 - $20 copay, depending on place of service If a primary care physician provides the Foot Care services, a $10 copay would apply. Otherwise, a $20 copay would apply.	$10 - $25 copay, depending on place of service If a primary care physician provides the Foot Care services, a $10 copay would apply. Otherwise, a $25 copay would apply.	$5 - $30 copay, depending on place of service If a primary care physician provides the Foot Care services, a $5 copay would apply. Otherwise, a $30 copay would apply.
Durable Medical Equipment/Supplies (e.g. wheelchairs, oxygen, etc.) [1]	You pay a 20% coinsurance	You pay a 20% coinsurance	You pay a 20% coinsurance
Diabetes Supplies and Services[1]	**Diabetes Monitoring Supplies:** • $0 copay **Diabetes Self-Management Training:** • $0 copay **Therapeutic Shoes or Inserts:** • $0 copay	**Diabetes monitoring supplies:** • $0 copay **Diabetes self-management training:** • $0 copay **Therapeutic shoes or inserts:** • $0 copay	**Diabetes monitoring supplies:** • $0 copay **Diabetes self-management training:** • $0 copay **Therapeutic shoes or inserts:** • $0 copay
Prosthetic Devices (braces, artificial limbs, etc.) **1**	**Prosthetic Devices:** • 20% coinsurance **Related Medical Supplies:** • 20% coinsurance	**Prosthetic Devices:** • 20% coinsurance **Related Medical Supplies:** • 20% coinsurance	**Prosthetic Devices:** • 20% coinsurance **Related Medical Supplies:** • 20% coinsurance
Renal Dialysis[1]	**Dialysis Services:** You pay a 20% coinsurance	**Dialysis Services:** You pay a 20% coinsurance	**Dialysis Services:** You pay a 20% coinsurance

Benefits	BlueJourney Premier (HMO)	BlueJourney Value (HMO)	BlueJourney Essential (HMO)
Wellness Programs (e.g. fitness)	**Supplemental Benefit – Fitness** (Silver&Fit) • $0 copay	**Supplemental Benefit – Fitness** (Silver&Fit) • $0 copay	**Supplemental Benefit – Fitness** (Silver&Fit) • $0 copay
Home Health Care[1]	You pay a $0 copay	You pay a $10 copay	You pay a $0 copay
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. You pay a $0 copay for Hospice consultation. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. You pay a $0 copay for Hospice consultation. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. You pay a $0 copay for Hospice consultation. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.
Acupuncture	**Not** covered	**Not** covered	**Not** covered
Over-the-Counter Items	$15 monthly allowance for Over-the-Counter (OTC) drugs and supplies. Unused allowance may not be carried over from one month to the next. Please visit our website to see our list of covered Over-the-Counter (OTC) items offered through an external vendor.	$15 monthly allowance for Over-the-Counter (OTC) drugs and supplies. Unused allowance may not be carried over from one month to the next. Please visit our website to see our list of covered Over-the-Counter (OTC) items offered through an external vendor.	$25 monthly allowance for Over-the-Counter (OTC) drugs and supplies. Unused allowance may not be carried over from one month to the next. Please visit our website to see our list of covered Over-the-Counter (OTC) items offered through an external vendor.

Standard Retail Cost-Sharing						
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**BlueJourney Essential (HMO)**		**BlueJourney Value (HMO)**		**BlueJourney Premier (HMO)**	
Deductible	You pay $0		You pay $0		You pay $0	
	One-month supply	Three-month supply	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1: Preferred Generics	$10 copay	$30 copay	$9 copay	$27 copay	$8 copay	$24 copay
Tier 2: Generic	$20 copay	$60 copay	$17 copay	$51 copay	$15 copay	$45 copay
Tier 3: Preferred Brand	$47 copay	$141 copay	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4: Non-Preferred Brand	$100 copay	$300 copay	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5: Specialty Brand	33% of the cost	Not offered	33% of the cost	Not offered	33% of the cost	Not offered
Part D excluded drugs	**Not** Covered		**Not** Covered		**Not** Covered	

Preferred Retail Cost-Sharing						
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**BlueJourney Essential (HMO)**		**BlueJourney Value (HMO)**		**BlueJourney Premier (HMO)**	
Deductible	You pay $0		You pay $0		You pay $0	
	One-month supply	Three-month supply	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1: Preferred Generics	$3 copay	$9 copay	$4 copay	$12 copay	$3 copay	$9 copay
Tier 2: Generic	$15 copay	$45 copay	$12 copay	$36 copay	$10 copay	$30 copay
Tier 3: Preferred Brand	$42 copay	$126 copay	$42 copay	$126 copay	$42 copay	$126 copay
Tier 4: Non-Preferred Brand	$95 copay	$285 copay	$95 copay	$285 copay	$95 copay	$285 copay
Tier 5: Specialty Brand	33% of the cost	Not offered	33% of the cost	Not offered	33% of the cost	Not offered
Part D excluded drugs	Not Covered		Not Covered		Not Covered	

Standard Mail Order Cost-Sharing						
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**BlueJourney Essential (HMO)**		**BlueJourney Value (HMO)**		**BlueJourney Premier (HMO)**	
Deductible	You pay $0		You pay $0		You pay $0	
	One-month supply	Three-month supply	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1: Preferred Generics	$10 copay	$30 copay	$9 copay	$27 copay	$8 copay	$24 copay
Tier 2: Generic	$20 copay	$60 copay	$17 copay	$51 copay	$15 copay	$45 copay
Tier 3: Preferred Brand	$47 copay	$141 copay	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4: Non-Preferred Brand	$100 copay	$300 copay	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5: Specialty Brand	33% of the cost	Not offered	33% of the cost	Not offered	33% of the cost	Not offered
Part D excluded drugs	Not Covered		Not Covered		Not Covered	

Preferred Mail Order Cost-Sharing						
Phase 1: Initial Coverage (Initial Coverage Limit is $3,750 in 2018)	**BlueJourney Essential (HMO)**		**BlueJourney Value (HMO)**		**BlueJourney Premier (HMO)**	
Deductible	You pay $0		You pay $0		You pay $0	
	One-month supply	Three-month supply	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1: Preferred Generics	$3 copay	$9 copay	$4 copay	$12 copay	$3 copay	$9 copay
Tier 2: Generic	$15 copay	$45 copay	$12 copay	$36 copay	$10 copay	$30 copay
Tier 3: Preferred Brand	$42 copay	$126 copay	$42 copay	$126 copay	$42 copay	$126 copay
Tier 4: Non-Preferred Brand	$95 copay	$285 copay	$95 copay	$285 copay	$95 copay	$285 copay
Tier 5: Specialty Brand	33% of the cost	Not offered	33% of the cost	Not offered	33% of the cost	Not offered
Part D excluded drugs	Not Covered		Not Covered		Not Covered	

Benefit	BlueJourney Essential (HMO)	BlueJourney Value (HMO)	BlueJourney Premier (HMO)
Initial Coverage	You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part **D** plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part **D** plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part **D** plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Coverage Gap **Coverage Gap continued**	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand drugs and 44% of the	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand drugs and 44% of the	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand drugs and 44% of the

Benefit	BlueJourney Essential (HMO)	BlueJourney Value (HMO)	BlueJourney Premier (HMO)
	plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under the plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.	plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under the plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.	plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under the plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an • $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an • $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an • $8.35 copayment for all other drugs.

Capital BLUE

Capital BlueCross is an Independent Licensee of the BlueCross BlueShield Association

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital BlueCross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interpete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

ગુજરાતીમા બોલે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្តាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

For help and information:

BlueJourney HMO
1-800-990-4201

Current members
1-866-779-6962 (TTY: 711)
8 a.m. to 8 p.m., Monday through Friday
(extended hours October 1 through February 14)

Capital BLUE

capbluecross.com | capitalbluestore.com

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

BlueJourney HMO is offered by Capital Advantage Insurance Company®, a Medicare Advantage organization with a Medicare contract. Enrollment in BlueJourney HMO depends on contract renewal.

Capital BlueCross and its subsidiaries Capital Advantage Insurance Company and Capital Advantage Assurance Company are independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

SOB18-03 (09/15/17)